PLACER COUNTY DEPARTMENT OF CHILD SUPPORT
SERVICES
11795 EDUCATION ST STE 101
AUBURN CA 95602-2469

CSE Case Number:
Custodial Party:

Noncustodial Parent:

Court Case Number:

Enclosed are the forms you must fill out to open a child support case.

Please read the Child Support Information Handbook and the Child Support Enforcement Program Notice carefully before you start filling out the forms. These forms tell you about services available to you, your rights and responsibilities, and the responsibilities of the Department of Child Support Services.

Bring/Mail Application

Bring or mail your completed application and a copy of any court orders you have to:

11795 EDUCATION ST STE 101
AUBURN CA 95602-2469

OR drop by the office at:

11795 EDUCATION ST STE 101
AUBURN CA 95602-2469

If you have questions, please call (866) 901-3212. Please have your case number ready. Thank you for your cooperation.

Sincerely,

Enclosures

NOTICE OF CHILD SUPPORT SERVICES PROGRAM

DCSS 0064 (08/25/05)

WHAT CHILD SUPPORT CAN DO FOR YOU:

All children have the right to be supported by both parents. Any person, including a noncustodial parent, whether or not he or she receives public assistance, can apply for support services. Support services are free. Some of the services available are:

- locating the parent(s) for child support enforcement purposes;
- establishing paternity (legal fatherhood);
- establishing a child and/or medical support (health insurance) order;
- enforcing a child and/or medical support order;
- changing an existing court order for child and/or medical support;
- enforcing a spousal support order with a child support order;
- collecting and distributing support payments.

CUSTODY AND VISITATION SERVICES ARE NOT PROVIDED.

THE LOCAL CHILD SUPPORT AGENCY PROVIDES SERVICES ON BEHALF OF THE COUNTY. THE LOCAL CHILD SUPPORT AGENCY DOES NOT REPRESENT YOU AND IS NOT YOUR ATTORNEY. BECAUSE YOU ARE NOT ITS CLIENT, THE LOCAL CHILD SUPPORT AGENCY MAY PROVIDE ENFORCEMENT SERVICES TO YOU OR THE OTHER PARENT IN THE FUTURE, AND THE INFORMATION YOU PROVIDE IS NOT PRIVILEGED OR KEPT CONFIDENTIAL UNDER ATTORNEY-CLIENT PRIVILEGE.

COOPERATION WITH CHILD SUPPORT

When you request services, you must cooperate with the local child support agency by providing any information or documents needed to establish paternity and/or locate the other parent and to get support payments for your child. Once you request services of the local child support agency, the local child support agency will determine the appropriate actions to take. All support payments must be made to the State Disbursement Unit. If payments are made directly to you, these payments must be turned over to the State Disbursement Unit.

When you apply for, or receive support services, you are responsible for promptly informing the child support agency of any changes that could affect your child support case or the work of the local child support agency. Some examples are:

- child leaves your home;
- telephone number or address changes (including a move to another county, state, or country);
- stopping public assistance, such as California Work Opportunity and Responsibility to Kids (CalWORKs);
- name change;
- initiation of divorce or other legal proceedings involving your child;
- information regarding the other party;
- direct receipt of any child, spousal or family support payment.

YOUR RIGHTS

You have the right to seek legal advice from a private attorney or legal services office at your own expense. If you hire an attorney, you must tell the local child support agency. For free information and/or legal assistance, you may contact the Superior Court's Office of the Family Law Facilitator. Free or reduced cost legal services may also be available at your legal services office.

If you have a support order in the State of California, you may ask the local child support agency to review your support order to determine if the amount of support should be changed based on statewide guidelines. If the amount of support does not meet guidelines for change, the local child support agency must give you or the other parent, upon request, information on how to get the forms to request the court to change the amount of support ordered. The Family Law Facilitator can also help free of charge. The local child support agency must tell you of the date, time, and purpose of every hearing for paternity or support. You have the right to read the court file, unless that information is legally prohibited by confidentiality requirements.

Upon your request, the local child support agency may give you copies of the most recent order entered in your case file. You can go to court to enforce your support order, but you must give the local child support agency advance notice that you intend to file your own enforcement action. If the local child support agency does not respond to your notice within thirty (30) days or if the local child support agency tells you that you can proceed, you can then file your own enforcement action with the Superior Court as long as all support is payable through the local child support agency.

The local child support agency must have the permission of a non-public assistance recipient before filing a stipulation affecting the support order in which that person is named as a party. The local child support agency cannot, without a public assistance recipient's consent, enter into a stipulation that will decrease the amount of overdue support when the recipient is owed overdue support that is more than the amount of public assistance paid to the recipient.

If you are not receiving public assistance, the payments the State receives are applied in the following order:

1. Current monthly support;
2. Interest;
3. Past due support; and
4. Future obligations.

Federal income tax refunds owed to the noncustodial parent can be intercepted by the child support agency, and are applied differently than other payments. By federal law, this money cannot be applied to current support obligations. It must be applied to the past due child support. If a custodial party has received public assistance, including Medi-Cal, the past due child support owed to the government will be paid first.

All case types that are eligible for Federal income tax refund offset are eligible for administrative offset. The following types of payments are available for administrative offset. They include both recurring and nonrecurring payments. Recurring payments are payments that are issued on a regular, routine, or repeated basis. A nonrecurring payment is issued once and not expected to be repeated, such as a lump-sum retirement payment.

The Federal payments currently included in administrative offset are: Federal retirement payments, vendor, and miscellaneous payments (i.e., expense reimbursement payments and travel payments).

Administrative Offset and Federal Tax Refund Offset are allowed by 31 United States Code Section 3716, 42 United States Code Section 664, 26 United States Code Section 6402, and 45 Code of Federal Regulations Section 303.72.

State income tax refunds and lottery awards owed to the noncustodial parent can also be intercepted by the child support agency and are applied according to the Child Support Program distribution regulations (Manual of Policy and Procedures, Sections 12-415 and 12-420). Franchise Tax Board intercept and lottery award collections are applied to all current support and then to past due child support, including past due medical support.

CALIFORNIA DOES NOT CHARGE AN APPLICATION FEE AND DOES NOT CHARGE FOR THE CHILD SUPPORT SERVICES PROVIDED TO APPLICANTS. HOWEVER, SOME STATES DO CHARGE A FEE FOR SERVICES. IF YOUR CASE INVOLVES ONE OF THOSE STATES, THEY MAY DEDUCT THE FEE FROM THE SUPPORT PAYMENTS, OR ADD IT TO THE BALANCE THAT IS OWED.

NOTICE OF COLLECTIONS AND DISTRIBUTION

Custodial Party will get a Notice of Collections and Distribution of support payments every month. The Notice will show all support that was collected and paid out during the period shown on the Notice, and if that money was applied to current support, or past due support. A Notice of Collections and Distribution will not be sent in any month that no support was received or paid out.

MEDICAL SUPPORT AND MEDI-CAL

Either or both parents can be required to provide health insurance if health insurance is available at a reasonable cost.

In general, the cost of health insurance is reasonable if it is employment-related group health insurance or other group health insurance. However, in determining reasonable cost, the court will also consider the actual cost of the health insurance to the parent(s).

The local child support agency will ask the court to establish or change a child support order to require the parent(s) to provide health insurance if it is available at a reasonable cost. The custodial parent may also request that the local child support agency change the child support order to include a provision for health insurance. This may affect the amount of the monthly child support obligation. If the noncustodial parent is ordered to provide health insurance coverage, the local child support agency will contact the noncustodial parent and his or her employer, if necessary, to secure health insurance for the child. After the local child support agency receives the policy information, the information will be given to the custodial parent.

Having private health insurance coverage does not prevent the Custodial Party from having Medi-Cal coverage. If the Custodial Party receives Medi-Cal and has individual or group health private coverage (including dental or vision coverage), the Custodial Party is required by federal and state law to tell the county welfare department (CWD), the health care provider, and the child support agency. Failure to provide this information is a misdemeanor. The Custodial Party must report to the CalWORKs eligibility worker and/or child support agency within ten (10) days when private health coverage changes or stops. The Custodial Party must also tell the CalWORKs eligibility worker and/or child support agency about any court order regarding health insurance.

If the Custodial Party is only receiving Medi-Cal, the Custodial Party must cooperate in establishing paternity and obtaining medical support as a condition of continued eligibility for Medi-Cal benefits, unless the Custodial Party has filed and the CWD has approved a claim of "good cause" (CA 51) for not cooperating. Your child(ren) will still be eligible for Medi-Cal. Also, all child support services will be given, unless the Custodial Party tells the local child support agency that he or she does not want services that are unrelated to obtaining medical support and establishing paternity. Obtaining medical support may reduce the amount of the child support received. In cases where both parents are in the home, the local child support agency will establish paternity only.

Under Federal law [42 U.S.C. Section 1396(a) (25)], health insurance belonging to a Medi-Cal recipient in a child or medical support enforcement case is used as follows:

The service provider will bill Medi-Cal. Medi-Cal will pay the service provider. Then Medi-Cal will seek repayment from the other health insurance coverage. You are not responsible for any insurance cost-sharing amount (co-insurance, co-payment or deductible) unless a Medi-Cal co-payment or share of cost must be met. The provider may bill you for the service if you do not cooperate in identifying your private health insurance. If your other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), you must use the plan facilities for regular medical care. Except for out-of-area service or emergency care, Medi-Cal will not pay for services provided by a provider not associated with your PHP/HMO. Out-of-area services or emergency care should be billed to the PHP/HMO.

FOR MORE INFORMATION ON CHILD SUPPORT SERVICES, PLEASE REFER TO YOUR CHILD SUPPORT HANDBOOK

NONDISCRIMINATION STATEMENT

It is the policy of the State of California to ensure that all individuals are treated equally and that no person shall, on the basis of ethnic group identification, race, color, national origin, political affiliation or belief, religion, sex, age or disability be excluded from participation in, denied the benefits of any program or service, or otherwise be subjected to treatment that is different than that provided to others.

Each local child support agency has a designated Civil Rights Coordinator. Any applicant/recipient who feels they have been subjected to discriminatory treatment may file a complaint of discrimination by first contacting the local child support agency's designated Civil Rights Coordinator through the State Customer Service Support Center (CSSC) or by writing to the California Department of Child Support Services, Attn: Human Services Section, Civil Rights Office, P.O. Box 419064, Rancho Cordova, CA 95741-9064 or call (866) 901-3212.

INSTRUCTIONS FOR COMPLETING THE SIMPLIFIED APPLICATION FOR CHILD SUPPORT SERVICES

DCSS 0373 (08/16/04)

The processing of your case depends upon the information you provide on this form. Please provide as much information as possible. Answer every question completely. If you do not know the answer, print "UNKNOWN." If the question does not apply, print "N/A."

Before you begin, please read the Child Support Handbook. This book explains the services available through the local child support agency. Also, read the Child Support Enforcement Program Notice. This notice explains your responsibility to the local child support agency and the local child support agency's responsibility to you. The local child support attorneys or Attorney General or any of their representatives are not your attorney or the child(ren)'s attorney.

Please complete all the forms in BLACK INK and PRINT clearly.

FACTS ABOUT CUSTODIAL PARTY OR GUARDIAN AND CHILD(REN)

This section is about the person or party who has primary custody of the child(ren). Please complete the entire section. If you are the custodial party, be sure to give us a telephone number where you may be reached during the day.

If the children named in the application have different noncustodial parents, a separate application must be completed for each noncustodial parent. If you need additional space for any section, attach a separate sheet of paper or use the Comment Section provided at the end of the first page.

Please list all the child(ren) of the parents named for whom support services are being requested. Complete the full name of each child, including first name, middle name, last name, and suffix (Jr., Sr., III, etc.)

There are several questions within this section related to determining the biological father of the child(ren) named in the application. One question asks whether a Declaration of Paternity has been signed. The Declaration of Paternity is a legal form that, when signed (usually at the hospital or clinic) by both parents, says the man is the legal father. Signing the form and submitting it to the Department of Child Support Services legally establishes the man as the child's father without having to go to court.

A second question asks whether a Paternity Judgment has been established. A Paternity Judgment is an order from the court that, through the legal process, determines the biological father of the child(ren). Determining the biological father is necessary before child support can be ordered by the court.

Comments: You may use this section as extra space, if needed, or add any additional information you think might help us establish or enforce an order for the child(ren). You may include information about the other person's temper, whether they own rifles or handguns, if they have made threats against you or the child(ren), etc.

FACTS ABOUT NONCUSTODIAL PARENT

If you are the Custodial Party, this section may require you to look through old papers to find some of the information requested. The more information we have in this section the better and faster we will be able to serve you.

If at all possible, please provide the noncustodial parent's Social Security Number or numbers. If you do not know the exact date of birth, provide the approximate age.

Please provide any and all financial information about the noncustodial parent. Attach additional page(s) as needed or use the Comment Section on the first page.

If you are the noncustodial party, be sure to give us a telephone number where you may be reached during the day.

SIGNATURE OF APPLICANT

We will not be able to open this case without your signature. Your signature indicates that you have answered the questions on the application to the best of your ability and that you want to open this case. It also indicates that you have read the information provided above the signature line carefully.

SIMPLIFIED APPLICATION FOR CHILD SUPPORT SERVICES

DCSS 0373 (08/16/04)

I AM THE: ☐ CUSTODIAL PARTY ☐ NONCUSTODIAL PARENT

APPLICANT NAME (PERSON COMPLETING THIS FORM)

NOTE: The custodial party is the person or party who has primary custody of the minor children.

FACTS ABOUT CUSTODIAL PARTY OR GUARDIAN AND CHILD(REN)

FULL NAME *(LAST, FIRST, MIDDLE)*		TELEPHONE NUMBERS HOME: WORK: CELL: OTHER *(SPECIFY)*	BEST TIME TO BE REACHED ☐ A.M. ☐ P.M.
MAIDEN NAME *(IF APPROPRIATE)* NAME OF CURRENT SPOUSE	RELATIONSHIP TO CHILD(REN) ☐ FATHER ☐ MOTHER ☐ OTHER *(SPECIFY)*		BEST NUMBER TO BE REACHED AT ☐ HOME ☐ CELL ☐ WORK ☐ OTHER
ADDRESS *(STREET, CITY, STATE AND ZIP CODE)*		E-MAIL ADDRESS	

Does the custodial party currently live with the noncustodial parent? ☐ YES ☐ NO *(If "NO", give date and address last lived together)*

DATE	ADDRESS *(STREET, CITY, STATE AND ZIP CODE)*

SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER	STATE	BIRTHDATE OR APPROXIMATE AGE	PLACE OF BIRTH	RACE	PRIMARY LANGUAGE SPOKEN IN HOME	GENDER ☐ FEMALE ☐ MALE

NAME OF PRESENT EMPLOYER - IF NOT CURRENTLY WORKING, PRINT "UNEMPLOYED" HERE	JOB TITLE OR OCCUPATION	GROSS MONTHLY EARNINGS $
ADDRESS OF PRESENT EMPLOYER *(STREET, CITY, STATE, AND ZIP CODE)*	IS HEALTH INSURANCE AVAILABLE FOR CHILDREN? ☐ YES ☐ NO	NAME AND TELEPHONE NUMBER OF A RELATIVE OR FRIEND

Date and place of marriage *(If never married, check "None")*

DATE OF MARRIAGE TO NONCUSTODIAL PARENT	COUNTY	STATE	☐ NONE

Date and place of divorce *(If no divorce, check "None")*

DATE OF DIVORCE	COUNTY	STATE	☐ NONE

If parents were NOT married, please answer questions 1-5 below.

1. Has noncustodial parent ever lived in California? ☐ YES ☐ NO If "YES", When? _____ Where? _____
2. Has noncustodial parent ever worked in California? ☐ YES ☐ NO If "YES", When? _____ Where? _____
3. In which state were the child(ren) conceived? *(Use number for each child listed below)*. Child #____ State____ Child #____ State____ Child #____ State ____
4. Was a Declaration of Paternity signed at a California hospital or agency? ☐ YES ☐ NO ☐ DON'T KNOW If "YES", Where? _____
5. Was a Paternity Judgment established? ☐ YES ☐ NO ☐ DON'T KNOW If "YES", Where? _____

Have services been provided by another child support agency? *(If "YES", please give the date, city and state)*

DATES OF SERVICES From: To:	CITY AND STATE WHERE SERVICES RECEIVED	HAVE THE MINOR CHILDREN RECEIVED CASH AID? (WELFARE) ☐ YES ☐ NO

Is the noncustodial parent court ordered to pay child support for the child(ren) named below? ☐ YES ☐ NO ☐ PENDING

COURT ORDER #	AMOUNT OF ORDER $ ☐ PER WEEK ☐ PER MONTH	DATE OF ORDER	COUNTY	STATE

List full names of all minor children by this noncustodial parent *(If child is not yet born, write "unborn", and expected date of birth).*
(A separate application is required for children from another noncustodial parent)

IF CHILD IS NOT YET BORN, WRITE "UNBORN" HERE	EXPECTED DATE OF BIRTH FOR UNBORN CHILD(REN)

NAME	SEX	BIRTHDATE	BIRTHPLACE (CITY AND STATE)	SOCIAL SECURITY NUMBER	CHILD(REN) LIVING WITH YOU	
1.					☐ YES	☐ NO
2.					☐ YES	☐ NO
3.					☐ YES	☐ NO
4.					☐ YES	☐ NO

List full names of other minor child(ren) NOT related to this noncustodial parent

NAME	BIRTHDATE	CHILD(REN) LIVING WITH YOU	
		☐ YES	☐ NO
		☐ YES	☐ NO

COMMENTS *(Please attach a separate sheet if you need additional space)*

FACTS ABOUT NONCUSTODIAL PARENT

FULL NAME *(LAST, FIRST, MIDDLE)*		TELEPHONE NUMBERS HOME: WORK: CELL: OTHER *(SPECIFY)*
MAIDEN NAME (IF APPROPRIATE) NAME OF CURRENT SPOUSE	RELATIONSHIP TO CHILD(REN) ☐ FATHER ☐ MOTHER	
OTHER NAMES OR ALIASES OF NONCUSTODIAL PARENT		E-MAIL ADDRESS
ADDRESS (STREET, CITY, STATE AND ZIP CODE)		☐ CURRENT NOW ☐ CURRENT AS OF (DATE)

SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER	STATE	BIRTHDATE OR APPROXIMATE AGE	PLACE OF BIRTH	GENDER ☐ FEMALE ☐ MALE

Currently on probation or parole? ☐ YES ☐ NO

Currently in jail or prison? ☐ YES ☐ NO **If "YES", provide information below:**

DATE	AGENCY	CITY	STATE	OFFENSE (REASON)

Is the noncustodial parent a US citizen? ☐ YES ☐ NO **IF "NO", Please provide country of citizenship here:**

PHYSICAL DESCRIPTION: *(PLEASE PROVIDE PHOTO)*

RACE	COMPLEXION	PRIMARY LANGUAGE
HAIR	HEIGHT	IDENTIFYING FEATURES (MARKS, SCARS, TATTOOS, ETC.)
EYES	WEIGHT	

NAME OF PRESENT EMPLOYER (IF NOT WORKING, PRINT "UNEMPLOYED")	☐ CURRENT NOW ☐ CURRENT AS OF (DATE)	IS HEALTH INSURANCE AVAILABLE FOR CHILDREN? ☐ YES ☐ NO	GROSS MONTHLY EARNINGS $
ADDRESS OF PRESENT EMPLOYER *(STREET, CITY, STATE AND ZIP CODE)*			

If unemployed or present employer is unknown, give name, address and telephone number of last employment below.

NAME OF LAST EMPLOYER	ADDRESS OF LAST EMPLOYER *(STREET, CITY, STATE AND ZIP CODE)*	TELEPHONE NUMBER *(INCLUDE AREA CODE)*

USUAL OCCUPATION, TRADE, JOB TITLE OR SKILLS	ACTIVE MILITARY: ☐ YES ☐ NO WHAT BRANCH OF THE SERVICE?

IS THE NONCUSTODIAL PARENT A LABOR UNION MEMBER? ☐ YES ☐ NO	NAME AND NUMBER OF UNION	ADDRESS OF UNION *(STREET, CITY, STATE AND ZIP CODE)*

IF SELF-EMPLOYED, WHAT IS THE NAME OF THE BUSINESS?	GROSS MONTHLY EARNINGS $
STEADY WORKER? ☐ YES ☐ NO IF NO, EXPLAIN:	

List any other sources of income or assets. ***(For example, Veterans Affairs benefits, Social Security Disability, interest, dividends, trust, vehicles, boats, real estate, etc. Attach a separate sheet if necessary).***

MOTHER'S MAIDEN NAME *(LAST, FIRST)*	MOTHER'S STREET ADDRESS, CITY, STATE AND ZIP CODE	MOTHER'S TELEPHONE NUMBER
FATHER'S NAME *(LAST, FIRST)*	FATHER'S STREET ADDRESS, CITY, STATE AND ZIP CODE	FATHER'S TELEPHONE NUMBER

Name and address of current spouse, friend, or relative.

NAME	RELATIONSHIP	STREET ADDRESS, CITY, STATE ZIP CODE	TELEPHONE NUMBER

Is there visitation with the children? ☐ YES ☐ NO **If "YES", how many times per month?**

Is there any other child support obligation(s)? ☐ YES ☐ NO **If "YES", please provide amount: $**

Is there any other minor child(ren) in the home? ☐ YES ☐ NO **If "YES", how many children?**

Present marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Living with another person

I request the services of the Department of Child Support Services to assist me in the following efforts: ***(Mark all that apply)***

☐ Establish paternity ☐ Obtain a child support order ☐ Enforce an existing child and spousal support order (including past due)	☐ Modify an existing child support order ☐ Obtain an order for medical insurance ☐ Enforce an existing medical insurance order	☐ No medical insurance enforcement needed at this time. The children have satisfactory medical insurance coverage through: ☐ Custodial Parent ☐ Noncustodial Parent

I am applying for support services under the Child Support Program of Title IV-D of the Social Security Act. I declare under penalty of perjury (Penal Code, Section 118) that this questionnaire has been examined by me and to the best of my knowledge and belief it is true and correct.

SIGNATURE OF APPLICANT	DATE

CONFIDENTIAL PATERNITY QUESTIONNAIRE (PART I)

DCSS 0095 (08/16/04)

CASE NAME

Please complete this form to the best of your ability.

Privacy Statement

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act of 1974 (Public Law 93-579) requires that this notice be provided when collecting personal information from individuals. Information requested on this form, including your Social Security Number, is used by the Department of Child Support Services (DCSS) for purposes of identification and communication with you. The DCSS is required, under Section 466(a)(13) of the Social Security Act, to collect the Social Security Number of any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgement. Social Security Number information is mandatory and will be kept on file at the local child support agency to locate and identify individuals and assets for the purpose of establishing, modifying, and enforcing child support obligations. Enrolling a child in health insurance may require the release of the child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the other parent. The information in your case may be discussed with or given to the State, other public agencies that can legally receive such information, and to the other parent or his/her attorney to the extent required by law.

1. Please fill out the following personal information for the mother.

Name of Mother			Date of Mother's Birth	
Address	Street	City	State	Zip Code
Social Security Number	Home Phone		Work Phone	Message Phone

2. Please fill out the following personal information for the child.

Name of Child	Date of Birth (or Expected Date)
Place of Birth	Social Security Number

3. Please fill out the following personal information for the father.

Name of Father			Date of Birth	
Last Known Address	Street	City	State	Zip Code
Last Known Phone	Home		Work	Message
Last Known Employment (Type, Business Name)				
Address of Last Known Employment				

Physical Description	Height	Weight	Hair Color	Eye Color	Complexion	Race

4. Are there any court orders naming the father of the child? ☐ Yes ☐ No

If Yes, please explain below:

Name of Court	Court Date	Case Number

(Name of father if determined by the court and address if other than above)
Result:

Amount of child support awarded:

If the court has determined paternity, or a signed Declaration of Paternity is filed with the State of California, no further answers are required. Sign at the end of the form.

WEBAPP

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CONFIDENTIAL PATERNITY QUESTIONNAIRE (PART I)

DCSS 0095 (08/16/04)

5. Were you married when you became pregnant? ☐ Yes ☐ No
If Yes, explain below:

Name of husband	Were you living with your husband at the time you became pregnant?	☐ Yes ☐ No
When did you separate?	Was your husband impotent or sterile at the time you became pregnant?	☐ Yes ☐ No

If you were living with your husband at the time you became pregnant and he was not impotent or sterile, then no further answers are required, sign below. If not, complete PART II after signing below.

6. Comments

I declare under penalty of perjury that the information on this form is true to the best of my knowledge and belief.

Signature			MM/DD/YYYY
Executed at	City	County	State

Note: If you signed outside of the State of California, this form should be notarized.

CONFIDENTIAL PATERNITY QUESTIONNAIRE (PART II)

DCSS 0095 (08/16/04)

If the father of your child(ren) is with you at your interview and will legally acknowledge paternity and cooperate in establishment of paternity, you do not need to complete Parts II and III at this time.

CASE NAME

1. Name of Mother

2. Date you became pregnant

Where?

Why do you believe that this date is correct?

3. Name the father listed on the birth certificate

If this is not the same person named in PART I, Question 3, please explain.

4. Did the father agree to the use of his name on your child's birth certificate?
☐ Yes ☐ No

5. Has the father ever seen the child?
☐ Yes ☐ No

If Yes, what did he say or do?

6. Did the father give you any money or articles for the child?
☐ Yes ☐ No

Explain:

7. Has the father ever lived with the child?
☐ Yes ☐ No

If Yes, when and where?

8. Did the father ever admit that the child was his?
☐ Yes ☐ No

Explain:

Give the names and addresses of persons to whom the father has admitted paternity.

9. Is the father willing to sign a statement admitting that he is the father?
☐ Yes ☐ No

10. Have you ever received correspondence (cards and letters) from the father referring to your pregnancy, to you as mother, or to the child?
☐ Yes ☐ No

When?

What did he say?

CONFIDENTIAL PATERNITY QUESTIONNAIRE (PART II)

DCSS 0095 (08/16/04)

11. Did you and the father ever live together? ☐ Yes ☐ No	If Yes, give dates.
Date(s) and Address(es):	
12. Were you and the father ever married? ☐ Yes ☐ No	If Yes, date of marriage.
Date of separation	
13. Did you have any sexual intercourse with anyone else during the month, the month before or the month after you became pregnant? ☐ Yes ☐ No	If Yes, give name(s) and address(es).

14. Comments

I declare under penalty of perjury that the information on this form is true to the best of my knowledge and belief.

Signature	Day, Month, Year Signed
Executed at City County State	

Note: If you signed outside of the State of California, this form should be notarized.

CONFIDENTIAL PATERNITY QUESTIONNAIRE (PART III)

DCSS 0095 (08/16/04)

If the father of your child(ren) is with you at your interview and will legally acknowledge paternity and cooperate in establishment of paternity, you do not need to complete Parts II and III at this time.

CASE NAME

1. Name of Mother

Name of Father

2. Why do you believe this person is the father of your child?

3. When did you begin dating the father of your child?

4. When and in which city or town did you first have sexual intercourse with the father?

5. When and in which city or town did you last have sexual intercourse with the father?

6. Please give the name(s) and address(es) of people (friends, relatives, neighbors, landlord) who have seen you with the father and where they saw you:

7. Did you ever register at a motel or hotel with the father?
☐ Yes ☐ No

If Yes, where and when?

Please give the name(s) and address(es) of anyone who saw you there together.

8. Did the father use any birth control method?
☐ Yes ☐ No

If Yes, please list the method used.

9. What was the date of your last menstrual period before this pregnancy?

10. What was the weight of the child at birth?

11. What was the name of your doctor during pregnancy?

Doctor's Address:

12. Was the father informed of your pregnancy?
☐ Yes ☐ No

By whom?

What did the father say?

Who else was present when he was informed?

13. Did you ever discuss your pregnancy condition with the father?
☐ Yes ☐ No

What was said?

Who else heard the discussions?

14. Did the father ever pay or promise to pay any other money to you during your pregnancy?
☐ Yes ☐ No

Explain:

CONFIDENTIAL PATERNITY QUESTIONNAIRE (PART III)

DCSS 0095 (08/16/04)

15. Did the father ever pay or promise to pay any doctor, hospital, or medical bills related to your pregnancy? ☐ Yes ☐ No	Explain:
16. Have you ever written to the father concerning the child? ☐ Yes ☐ No	When?
What did you say?	
17. Does the child resemble the father? ☐ Yes ☐ No	In what way?
18. Has the father ever claimed the child on his income tax? ☐ Yes ☐ No	When?

19. Comments

I declare under penalty of perjury that the information on this form is true to the best of my knowledge and belief.

Signature	Day, Month, Year Signed

Executed at	City	County	State

Note: If you signed outside of the State of California, this form should be notarized.

REQUEST FOR SUPPORT SERVICES

DCSS 0055 (08/16/04) CSE Case Number:

INSTRUCTIONS: Read carefully before signing each of the areas below. Your signature is required in both places in order for us to open a case for you.

I want the local child support agency to help me get a child support order to establish paternity for the child(ren) or enforce a support order I have.

I understand that I am applying for these services under the Child Support Services Program under Title IV-D of the Social Security Act.

I will let the child support agency know right away:

- When each child marries.
- When each child reaches age 19 years or when child reaches age 18 years and is not a full-time student, whichever happens first.
- If my home address, mailing address, or telephone number changes.
- If my employer, including name, address, and telephone number changes.
- If my income changes.
- If my status, cost, or availability of health insurance coverage changes.
- If any information regarding the whereabouts of the other parent(s) changes.
- If the parent(s) moves back in together with the children, or
- If there is any change in custody, childcare or visitation.

I am aware that the local child support agency does not represent me, the other parent, or the children who are the subject of this case. No attorney-client relationship exists between the local child support agency and me, the other parent, or the children. No attorney-client relationship will arise if the local child support agency provides the support services I have requested.

I declare under penalty of perjury that I have read, understand, and agree to all of the terms specified above.

PRINT NAME _____ SIGNATURE _____ DATE _____

DD2014537146

CSE Case Number:
Custodial Party:

Noncustodial Parent:

Court Case Number:

The Department of Child Support Services (DCSS) is required by law to send child support case information to the federal government. The federal government maintains a data base that includes all child support cases in the country. Upon request, the federal government will release case information to other child support agencies; however, if you or the child(ren) in this case are the victim of family violence, you may not want the release of your case information.

If you think that releasing information about your case to the federal government may cause physical or emotional harm to you or the child(ren) in this case, please fill out the enclosed Family Violence Questionnaire (DCSS 0048) and return it to the address listed below within 30 days from the date of this letter. You must fill out the form completely in order to process your request. If you do not return this form within 30 days from the date on this letter, DCSS will release your information to the federal government.

Please mail the completed form to:
PLACER COUNTY DEPARTMENT OF
CHILD SUPPORT SERVICES
11795 EDUCATION ST STE 101
AUBURN CA 95602-2469

OR

Drop by the office at:
11795 EDUCATION ST STE 101
AUBURN CA 95602-2469

If you or the child(ren) in this case are not a victim of family violence, you do not have to return this form. Also, it is important to understand that DCSS is prohibited by law from releasing your personal information in this case to the other party without a court order. However, some documents that include some of your personal information may be filed with the court.

Please contact us at (866) 901-3212 with the above case number if you have any questions.

Sincerely,

Enclosures

FAMILY VIOLENCE QUESTIONNAIRE

DCSS 0048 (08/18/05)

INSTRUCTIONS: If you do not complete and return this form to us, the federal government will release information about you or the child(ren)'s whereabouts to courts, child support agencies, and possibly to the other party for the child(ren) in this case.

Your name: _____ Case Number:

Other party's name: _____

SECTION I: Check the appropriate box for each of the questions.

1. Have you or a child(ren) in this case ever been a victim of family violence or child abuse committed by the other party in this child support case? ☐ Yes ☐ No

2. Do you have a restraining order, emergency protective order or stay away order against the other party in this child support case? ☐ Yes ☐ No
   If yes, please attach a copy of this order and provide the following information:

   County/State: _____ Order/Docket Number: _____

   Expiration Date: _____

3. If you or the child(ren) in this case receive public assistance, do you want the welfare department to review this case to determine eligibility to close this support case because of the increased risk of physical, sexual, or emotional harm to you or the child(ren) in this case, by the other party? This is called having "good cause" to close the support case. ☐ Yes ☐ No

SECTION II: You MUST complete this section if you answered "Yes" to any item in SECTION I.

Please provide detailed family violence information including dates, times, places, and witnesses. (Attach additional page if needed).

FAMILY VIOLENCE QUESTIONNAIRE

DCSS 0048 (08/18/05)

SECTION III: If appropriate please check the box below, sign, date, and return this form to:

PLACER COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES
11795 EDUCATION ST STE 101
AUBURN CA 95602-2469

☐ Giving out my address or other information identifying my location could be harmful to me or the child(ren) in this case. I am requesting that my address or other identifying information not be given to the other party in this case. This request will stay in effect until I let the PLACER COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES know **in writing** that they may now give out my information, and the PLACER COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES tells me that they have received my request. I understand that under federal law, an authorized person may make a written request to the court that has jurisdiction to make or enforce child support or visitation determinations for release of my information. The local child support agency will let me know in writing if the court orders the release of any information on my case.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

PRINT NAME _____ SIGNATURE _____ DATE _____

VISITATION VERIFICATION

DCSS 0053 (08/29/05)

CSE Case Number:

Name of person completing form:	I am the ☐ Custodial Party ☐ Noncustodial Parent

PART 1. ACTUAL VISITATION BY THE NONCUSTODIAL PARENT

INSTRUCTIONS:

Complete the visitation history for the past 12 months by filling in the last 12 months and number of hours each month the noncustodial parent visited with the child(ren).

Example: If the last 12 months are June 2002 through May of 2003, you will complete June through December on the left side of the chart below. You would put 2002 for the year. Then you would complete the right side of the chart with January through May and put 2003 for the year.

MONTH/YEAR	NUMBER OF HOURS THE NONCUSTODIAL PARENT VISITED WITH THE CHILD(REN) EACH MONTH	MONTH/YEAR	NUMBER OF HOURS THE NONCUSTODIAL PARENT VISITED WITH THE CHILD(REN) EACH MONTH
January/		January/	
February/		February/	
March/		March/	
April/		April/	
May/		May/	
June/		June/	
July/		July/	
August/		August/	
September/		September/	
October/		October/	
November/		November/	
December/		December/	
	TOTAL:		TOTAL:

WEBAPP

PART 2. SHARED CUSTODY/VISITATION

CHECK ONE: ☐ Shared Custody ☐ Visitation Only ☐ Neither

VISITATION HOURS:

Regular Visitation:

From (specify day of the week) at (specify time) (Circle one) a.m./p.m.

To (specify day of the week) at (specify time) (Circle one) a.m./p.m.

Vacation Visitation: ☐ Yes ☐ No
If Yes, please specify dates/times:

Summer Visitation: ☐ Yes ☐ No
If Yes, please specify dates/times:

Overnight Visitation: ☐ Yes ☐ No
If Yes, please specify dates/times:

Court-ordered custody/visitation arrangement: ☐ Yes ☐ No

Additional Information:

I declare to the best of my knowledge and belief that the above information is true and correct. I am aware that this information may be provided to the other parent for their verification and that either party may be required to provide documentation.

PRINT NAME SIGNATURE DATE

CHILD CARE VERIFICATION

DCSS 0069 (08/16/04)

APPLICANT NAME: I am the ____ Custodial Party ____ Noncustodial Parent

APPLICANT: ***Give this form to your childcare provider to complete before you return it to the local child support agency. Attach any receipts or copies of canceled checks for child care.***

CHILD CARE PROVIDER: ***Please complete the appropriate section(s) for the children of the above named applicant for whom you provide child care. Then sign and date at the end of this form.***

SECTION I: INFANT & PRE-SCHOOL CHILD(REN)

Name of Provider/Day Care Center _____

Address _____

City _____ State _____ Zip _____ Phone (___) _____

Name of a person(s) who pays you for childcare _____

Name of the child(ren) of this parent for whom you provide care and the amount paid.

(*Circle One*)

Child _____ Amount $_____ per day/week/month

Child _____ Amount $ _____ per day/week/month

Child _____ Amount $ _____ per day/week/month

Total: $ _____ per day/week/month

SECTION II: SCHOOL-AGE CHILD(REN)

A. Child care provided during regular school sessions:

Name of Provider/Day Care Center _____

Address _____ Apt. or Unit No. _____

City _____ State _____ Zip _____ Phone (___) _____

Name of a person(s) who pays you for childcare _____

Name of the child(ren) of this parent for whom you provide care and the amount you receive.

(*Circle One*)

Child _____ Amount $_____ per day/week/month

Child _____ Amount $ _____ per day/week/month

Child _____ Amount $ _____ per day/week/month

Total: $ _____ per day/week/month

B. Summer/vacation care for school-age child(ren). Include amounts in the information specified below.

Name of Provider/Day Care Center _____

Address _____

City _____ State _____ Zip _____ Phone (___) _____

Name of a person(s) who pays you for childcare _____

_____

Name of the child(ren) of this parent for whom you provide care and the amount you receive.

(Circle One)

Child _____ Amount $_____ per day/week/month

Child _____ Amount $ _____ per day/week/month

Child _____ Amount $ _____ per day/week/month

Total: $ _____ per day/week/month

_____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

SIGNATURE DATE

HEALTH INSURANCE INFORMATION

DCSS 0054 (04/27/05)

County: PLACER Phone: LCSA Case Number:

Noncustodial Parent:

Full Name (First, Middle, Last, Suffix)	I am the ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer
Address (Street)	City, State, Zip Code
Phone	Social Security Number

Employer (Name, street, city, state, zip code, phone)

INSTRUCTIONS: ***Please complete SECTION I if health insurance is provided or available by the Noncustodial Parent or employer. SECTION II is about the other parent's insurance. Employers complete Sections I and III only. Please sign and date the completed form.***

SECTION I: YOUR HEALTH INSURANCE

HEALTH INSURANCE:

Do you currently have Health Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Health Insurance Company or Union (provide Union Local number)	Provided by: ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer ☐ Other: Relationship:
Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)	Telephone Number (*include Area Code*)
City State Zip Code	Policy Number
Premium Amount $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly
Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of Health Insurance $ / Cost to add additional child $

Dependent(s) Currently Covered By Health Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Health Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

The Policy covers the following: (Check all that apply)

☐ Doctor Visits ☐ Medicare Supplemental ☐ Specific Illness ☐ Prescription Drugs

☐ Long Term Care ☐ Hospital Stays ☐ Hospital Outpatient *(i.e., lab work, physical therapy)* ☐ Other (Specify):

DENTAL INSURANCE:

Do you currently have Dental Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Dental Insurance Company

Dental Insurance Company's Address: Street, Apartment Number or Unit Number (*address where claims are mailed*)

City	State	Zip Code	Policy Number

Premium Amount $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly

Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of health insurance $	Cost to add additional child $

Dependent(s) Covered by Dental Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Dental Insurance are listed on a separate sheet of paper. Please attach the sheet.

☐ Not available to dependents

VISION INSURANCE:

Do you currently have Vision Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Vision Insurance Company

Vision Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City	State	Zip Code	Policy Number

Premium Amount $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly

Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of health insurance $	Cost to add additional child $

Dependent(s) Covered by Vision Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Vision Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

SECTION II: OTHER PARENT'S INSURANCE

HEALTH INSURANCE:
Does the other parent currently provide Health Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Health Insurance Company

Health insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City State Zip Code

DENTAL INSURANCE:
Does the other parent currently provide Dental Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Dental Insurance Company

Dental Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City State Zip Code

VISION INSURANCE:
Does the other parent currently provide Vision Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Vision Insurance Company

Vision Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City State Zip Code

SECTION III: (MUST BE COMPLETED)

☐ I have enclosed the insurance card(s)/information about the coverage for the child(ren).

☐ At this time I do not have the insurance cards/information about the coverage for the child(ren). I will send the information to you when I get it from the insurance company.

☐ At this time there is no health insurance coverage available. I understand that if it becomes available, I will have to add my child(ren) onto the plan and then notify the local child support agency of the coverage. Coverage is unavailable because:

☐ Not offered ☐ Seasonal ☐ Part-Time ☐ Refused enrollment ☐ Unreasonable in cost ☐ Probationary period/date eligible

PRIVACY STATEMENT

The information Practices Act of 1997 (Civil Code Section 1798.17) and the Federal Privacy Act of 1974 (Public Law 93-579) require this notice be provided when collecting personal information from individuals. Information requested on this form, including Social Security Number, is used by the Department of Child Support Services (DCSS) for purposes of identification and communication with you. The DCSS is required, under Section 466 (a)(13) of the Social Security Act, to collect the Social Security Number of any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgement.

Social Security Number information is mandatory and will be kept on file at the local child support agency to locate and identify individuals and assets for the purpose of establishing, modifying, and enforcing child support obligations. Enrolling a child in health insurance may require the release of the child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the other parent.

The information in your case may be discussed with or given to the State, other agencies that can legally receive such information, and to the other parent or his/her attorney to the extent required by law.

SIGNATURE

DATE

PRINTED NAME

TELEPHONE (include Area Code)

TITLE

FL-150

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address):*	*FOR COURT USE ONLY*
TELEPHONE NO.: E-MAIL ADDRESS *(Optional):* ATTORNEY FOR *(Name):*	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT/CLAIMANT:	
INCOME AND EXPENSE DECLARATION	CASE NUMBER:

1. **Employment** *(Give information on your current job or, if you're unemployed, your most recent job.)*

Attach copies of your pay stubs for last two months (black out social security numbers).

a. Employer:
b. Employer's address:
c. Employer's phone number:
d. Occupation:
e. Date job started:
f. If unemployed, date job ended:
g. I work about hours per week.
h. I get paid $ gross (before taxes) ☐ per month ☐ per week ☐ per hour.

(If you have more than one job, attach an 8½-by-11-inch sheet of paper and list the same information as above for your other jobs. Write "Question 1—Other Jobs" at the top.)

2. **Age and education**
   a. My age is *(specify):*
   b. I have completed high school or the equivalent: ☐ Yes ☐ No If no, highest grade completed *(specify):*
   c. Number of years of college completed *(specify):* ☐ Degree(s) obtained *(specify):*
   d. Number of years of graduate school completed *(specify):* ☐ Degree(s) obtained *(specify):*
   e. I have: ☐ professional/occupational license(s) *(specify):*
      ☐ vocational training *(specify):*

3. **Tax information**
   a. ☐ I last filed taxes for tax year *(specify year):*
   b. My tax filing status is ☐ single ☐ head of household ☐ married, filing separately
      ☐ married, filing jointly with *(specify name):*
   c. I file state tax returns in ☐ California ☐ other *(specify state):*
   d. I claim the following number of exemptions (including myself) on my taxes *(specify):*

4. **Other party's income.** I estimate the gross monthly income (before taxes) of the other party in this case at *(specify):* $
   This estimate is based on *(explain):*

(If you need more space to answer any questions on this form, attach an 8½-by-11-inch sheet of paper and write the question number before your answer.) Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the information contained on all pages of this form and any attachments is true and correct.

Date:

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
FL-150 [Rev. January 1, 2007]
WEBAPP

DD2014537151

Family Code, §§ 2030–2032, 2100–2113, 3552, 3620–3634, 4050–4076, 4300–4339
www.courtinfo.ca.gov

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT/CLAIMANT:	CASE NUMBER:

Attach copies of your pay stubs for the last two months and proof of any other income. Take a copy of your latest federal tax return to the court hearing. ***(Black out your social security number on the pay stub and tax return.)***

5. **Income** *(For average monthly, add up all the income you received in each category in the last 12 months and divide the total by 12.)*

	Last month	Average monthly
a. Salary or wages (gross, before taxes)	$	
b. Overtime (gross, before taxes)	$	
c. Commissions or bonuses	$	
d. Public assistance (for example: TANF, SSI, GA/GR) or bonuses ☐ currently receiving	$	
e. Spousal support ☐ from this marriage ☐ from a different marriage	$	
f. Partner support ☐ from this domestic partnership ☐ from a different domestic partnership	$	
g. Pension/retirement fund payments	$	
h. Social security retirement (not SSI)	$	
i. Disability: ☐ Social security (not SSI) ☐ State disability (SDI) ☐ Private insurance	$	
j. Unemployment compensation	$	
k. Workers' compensation	$	
l. Other (military BAQ, royalty payments, etc.) *(specify):*	$	

6. **Investment income** *(Attach a schedule showing gross receipts less cash expenses for each piece of property.)*

a. Dividends/interest	$	
b. Rental property income	$	
c. Trust income	$	
d. Other *(specify):*	$	

7. **Income from self-employment, after business expenses for all businesses** $

I am the ☐ owner/sole proprietor ☐ business partner ☐ other *(specify):*
Number of years in this business *(specify):*
Name of business *(specify):*
Type of business *(specify):*

Attach a profit and loss statement for the last two years or a Schedule C from your last federal tax return. Black out your social security number. If you have more than one business, provide the information above for each of your businesses.

8. ☐ **Additional income.** I received one-time money (lottery winnings, inheritance, etc.) in the last 12 months *(specify source and amount):*

9. ☐ **Change in income.** My financial situation has changed significantly over the last 12 months because *(specify):*

10. **Deductions**

	Last month
a. Required union dues	$
b. Required retirement payments (not social security, FICA, 401(k), or IRA)	$
c. Medical, hospital, dental, and other health insurance premiums *(total monthly amount)*	$
d. Child support that I pay for children from other relationships	$
e. Spousal support that I pay by court order from a different marriage	$
f. Partner support that I pay by court order from a different domestic partnership	$
g. Necessary job-related expenses not reimbursed by my employer *(attach explanation labeled "Question 10g")*	$

11. **Assets**

	Total
a. Cash and checking accounts, savings, credit union, money market, and other deposit accounts	$
b. Stocks, bonds, and other assets I could easily sell	$
c. All other property, ☐ real and ☐ personal *(estimate fair market value minus the debts you owe)*	$

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT/CLAIMANT:	CASE NUMBER:

12. **The following people live with me:**

Name	Age	How the person is related to me? *(ex: son)*	That person's gross monthly income	Pays some of the household expenses?
a.				☐ Yes ☐ No
b.				☐ Yes ☐ No
c.				☐ Yes ☐ No
d.				☐ Yes ☐ No
e.				☐ Yes ☐ No

13. **Average monthly expenses** ☐ Estimated expenses ☐ Actual expenses ☐ Proposed needs

a. Home:

(1) ☐ Rent or ☐ mortgage. . . $ _____

If mortgage:

(a) average principal: $ _____

(b) average interest: $ _____

(2) Real property taxes . . . . . $ _____

(3) Homeowner's or renter's insurance (if not included above) . . . . . $ _____

(4) Maintenance and repair . . . . . $ _____

b. Health-care costs not paid by insurance. . . $ _____

c. Child care . . . . . $ _____

d. Groceries and household supplies. . . . . $ _____

e. Eating out. . . . . $ _____

f. Utilities (gas, electric, water, trash) . . . . . $ _____

g. Telephone, cell phone, and e-mail . . . . . $ _____

h. Laundry and cleaning . . . . . $ _____

i. Clothes . . . . . $ _____

j. Education. . . . . $ _____

k. Entertainment, gifts, and vacation. . . . . $ _____

l. Auto expenses and transportation (insurance, gas, repairs, bus, etc.) . . . . . $ _____

m. Insurance (life, accident, etc.; do not include auto, home, or health insurance) . . . . . $ _____

n. Savings and investments. . . . . $ _____

o. Charitable contributions. . . . . $ _____

p. Monthly payments listed in item 14 *(itemize below in 14 and insert total here)*. . $ _____

q. Other *(specify)*: . . . . . $ _____

r. **TOTAL EXPENSES** (a–q) *(do not add in the amounts in a(1)(a) and (b))* $ _____

s. **Amount of expenses paid by others** $ _____

14. **Installment payments and debts not listed above**

Paid to	For	Amount	Balance	Date of last payment
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

15. **Attorney fees** *(This is required if either party is requesting attorney fees.)*:

a. To date, I have paid my attorney this amount for fees and costs *(specify)*: $

b. The source of this money was *(specify)*:

c. I still owe the following fees and costs to my attorney *(specify total owed)*: $

d. My attorney's hourly rate is *(specify)*: $

I confirm this fee arrangement.

Date:

(TYPE OR PRINT NAME OF ATTORNEY)

(SIGNATURE OF ATTORNEY)

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT/CLAIMANT:	CASE NUMBER:

CHILD SUPPORT INFORMATION

(NOTE: Fill out this page only if your case involves child support.)

16. **Number of children**
    a. I have *(specify number):* children under the age of 18 with the other parent in this case.
    b. The children spend percent of their time with me and percent of their time with the other parent.
    (If you're not sure about percentage or it has not been agreed on, please describe your parenting schedule here.)

17. **Children's health-care expenses**
    a. ☐ I do ☐ I do not have health insurance available to me for the children through my job.
    b. Name of insurance company:
    c. Address of insurance company:

    d. The monthly cost for the **children's** health insurance is or would be *(specify)*:$
    (Do not include the amount your employer pays.)

18. **Additional expenses for the children in this case** Amount per month
    a. Child care so I can work or get job training. . . . . $ _____
    b. Children's health care not covered by insurance . . . . . $ _____
    c. Travel expenses for visitation . . . . . $ _____
    d. Children's educational or other special needs *(specify below)*: . . . . . $ _____

19. **Special hardships.** I ask the court to consider the following special financial circumstances *(attach documentation of any item listed here, including court orders)*:

	Amount per month	For how many months?
a. Extraordinary health expenses not included in 18b.	$ _____	_____
b. Major losses not covered by insurance (examples: fire, theft, other insured loss)	$ _____	_____
c. (1) Expenses for my minor children who are from other relationships and are living with me	$ _____	_____
(2) Names and ages of those children *(specify)*:		
(3) Child support I receive for those children.	$ _____	

The expenses listed in a, b, and c create an extreme financial hardship because *(explain)*:

20. **Other information I want the court to know concerning support in my case** *(specify)*:

State of California - Health and Human Services Agency

Department of Child Support Services

DECLARATION OF SUPPORT PAYMENT HISTORY

Person completing this form *(name)*: _____

I am the ☐ Custodial Party ☐ Noncustodial Parent

Support Payment History For *(check one)*: ☐ Child ☐ Spousal ☐ Family ☐ Medical

☐ Unreimbursed medical expenses ☐ Other *(specify)*:

YEAR _____ YEAR _____ YEAR _____

	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

YEAR _____ YEAR _____ YEAR _____

	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I am aw are that this may be provided to the other parent for their verification and that either party may be required to provide documentation.

Signature: _____ Date: _____

CSE CASE NO.:

INSTRUCTIONS FOR COMPLETING THE

DECLARATION OF SUPPORT PAYMENT HISTORY

The reverse of this page is your declaration of the support payment history for your case. You are asked to complete a month-by-month, year-by-year breakdown of the amounts of support that were due (ordered by the court) and the amount of each payment that was made. These figures will help determine the amount of past due support owed, if any.

You must complete a separate page (or pages) for child support, spousal support, family support, medical support, unreimbursed medical expenses, and other types of support not listed. **DO NOT combine child support and spousal support unless your court order combines the two support payments into a "family" support order.**

In the Amount Ordered column, fill in the amount of support that became due each month since your court order began. If there has been a change in your court order, make sure each month reflects the correct amount of support due.

In the Amount Paid column, indicate a dollar amount of support paid in that month. If more than one payment was made in a given month, put the total dollar amount of support paid. **Put the dollar amounts next to the month in which the payment was actually made, and not the month or months which those payments were intended to cover.** You may attach additional sheets as necessary.

Be aware that this declaration is not confidential and may be given to the other parent in your case for review. If there is a disagreement regarding the payment history, the parties may be required to present proof of payments in the form of canceled checks, receipts, etc.

Complete this Declaration neatly and correctly to make sure there is no mistake nor confusion as to the amounts of past due support owed, if any.